Women's self-reported experiences using misoprostol obtained from drug sellers: a prospective cohort study in Lagos State, Nigeria

Appendix A
Full description of recruitment and retention methodology

1. Mapping drug sellers

The mapping component was designed to enumerate the universe (sampling frame) of patent and proprietary medicine vendors (PPMVs) and registered pharmacy shops (referred to collectively as drug sellers) whom, based on advice by in-country experts, are likely the largest providers of medical abortion to women in this context. PPMVs are owner-operated drug retail outlets that were established as a category of retailer by the Ministry of Health to provide a source of medicine in communities with limited access to essential health commodities. For many people, they serve as the first point of care for a wide range of health issues. PPMV licensure does not require medical or pharmaceutical training, and regulations permit them to sell pre-packaged and over-the-counter medicines and medical products, but prohibit them from selling prescription medicines. In contrast, pharmacists must have a formal degree in pharmacy and are permitted to sell prescription medications. Official licensing of PPMVs and retail pharmacies is overseen by the Pharmacists Council of Nigeria (PCN), however there are an additional unknown number of unlicensed PPMVs in Nigeria; thus the study team conducted a mapping to generate a list of all drug sellers operating in the selected LGAs. The research team obtained a list of registered pharmacies from PCN's Lagos State office and two datasets that included a listing of all PPMVs that were operating in 16 states in 2013 (from Society of Family Health Nigeria) and all drug stores in Nigeria in 2015 (from Population Services International). These lists were used as a starting point for the sampling frame. A full mapping of PPMVs and pharmacies within the selected local government areas (LGAs) was conducted to determine the updated universe of drug sellers. All components of fieldwork (detailed in points 1-4) were conducted in two phases 1) Lagos Mainland, Ojo, and Oshodi/Isolo LGAs during April to July 2018 and 2) Epe, Ibeju-Lekki, and Ikorodu LGAs from May to October 2018.

Two supervisors and 18 fieldworkers were assigned to each LGA in the study to map all registered and unregistered drug sellers with a static point of sale (e.g., a store) whose primary business was selling medicines; clinicians or drug sellers without a shop or fixed point of sale were not included in the mapping exercise. Staff from the National Population Commission (NPopC) served as field guides and provided each field team with maps of the enumeration areas and an orientation to the LGA, including boundaries, streets and community names. LGA supervisors and NPopC staff overlaid NPopC maps with Google Maps to improve delineation of survey areas and reduce the potential for duplicated visits to drug sellers between teams in the field. Supervisors worked closely with the Field Managers to assign each fieldwork team sections of the LGA to map. Each data collection team in the field was comprised of two fieldworkers, one male and one female, to ensure their safety.

During mapping, no direct contact was made with anyone in the drug stores; the exercise was primarily to compile a list of existing stores in each LGA. GPS coordinates were collected using the data collection software *SurveyCTO Collect* along with a written description of the location to ensure field team members were able to return to the drug seller in future study components. After mapping was completed, the resulting dataset included: LGA, address, name of drug store, GPS coordinates, and a randomly generated unique ID. The Field Manager generated new project ID numbers for each drug seller in the sample, which were used to identify and link information on each drug seller throughout the study. All data were collected electronically using Android tablets. Data collected during the study were encrypted from the time of data collection, transmission to the secure server, and when downloaded to secured computers. Tablets used for data collection were password-protected and completed consent forms and surveys were uploaded to a secure server at the end of each day, which only the research team could access. The field team also carried paper copies of the instruments, in the case of power or mechanical failure.

The mapping exercise identified 896 drug stores in the selected LGAs (Appendix A, Figure 1).

2. Screening drug sellers

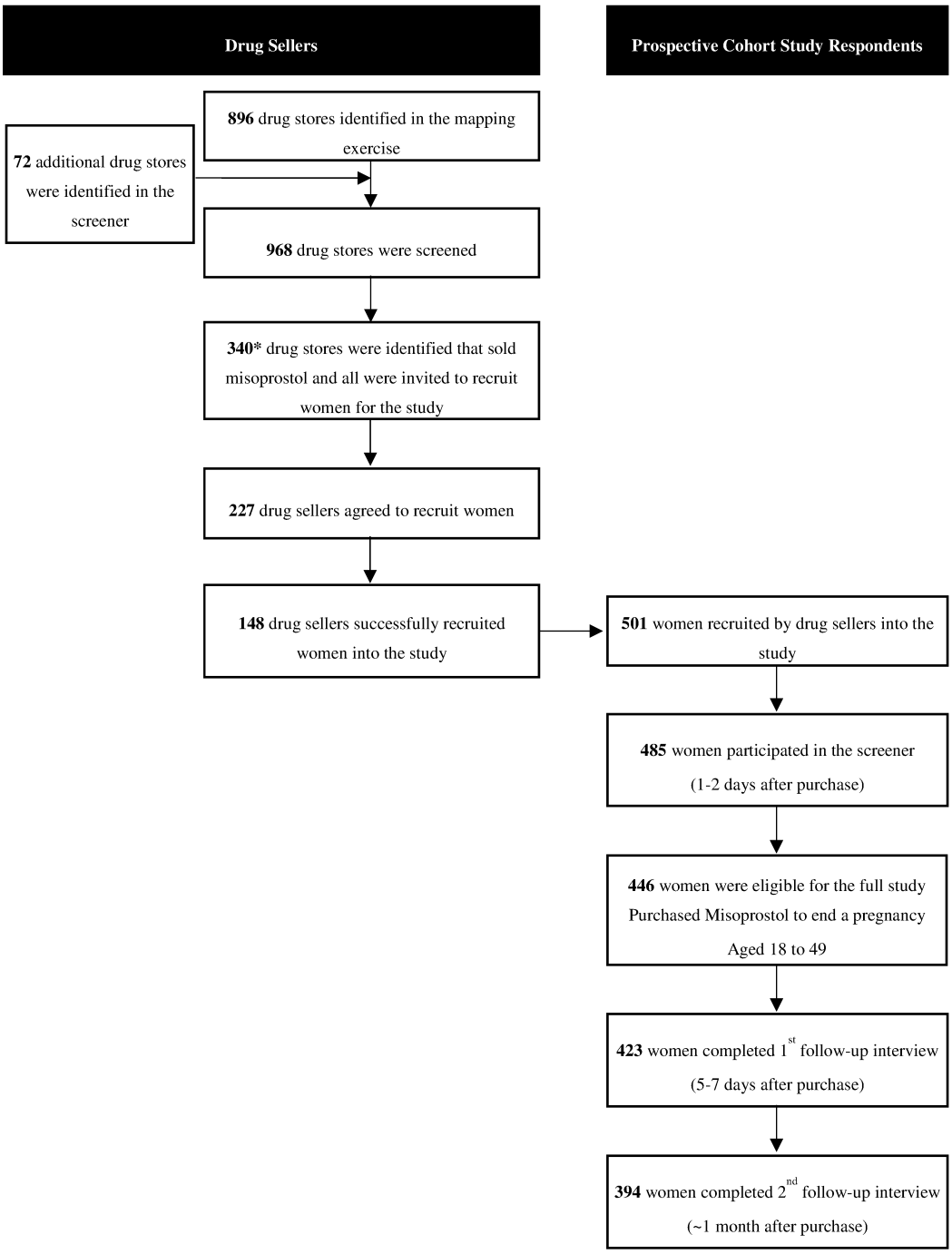
After the mapping was complete, interviewers who were not previously involved in the mapping component conducted short screening interviews of all drug sellers identified to determine whether they sold misoprostol-containing drugs. Two supervisors and approximately eight interviewers were assigned to each LGA for the drug seller screening component of the study.

Before beginning fieldwork, the research team formally notified the relevant government agencies and interacted significantly with the officials of the Pharmaceutical Services Directorate of the State Ministry of Health to secure their support and facilitate linkages with relevant stakeholders. Investigators contacted the leadership of the drug sellers associations and unions at the state as well as local levels to facilitate community entry. The study team gained approval from the following professional organizations: Association of Community Pharmacists of Nigeria (ACPN); and Lagos State Medicine Dealers Association (LSMDA). Each organization notified their membership about the study and provided letters of introduction for the study team to present to drug sellers prior to the interviews. Fieldworkers were also provided with the Lagos State Health Research Ethics Committee IRB approval letter, as well as identification cards to confirm their role on the study team to drug sellers while conducting fieldwork activities. The protocol for community entry was developed after the study team had conducted a small pilot study in another state, which revealed potential difficulties around interviewing drug sellers without the documentation of approvals at the local and national levels. These steps proved to be critical, and should be considered for other studies involving drug sellers in Nigeria.

Interviewers provided drug sellers with an introduction to the study and obtained permission from the owner or manager of each drug store to conduct the screener interview. If the owner or manager of the store was unavailable, interviewers were instructed to inquire when they could return to speak with them. If permission was granted, the interviewer explained the study to the drug seller who would be participating in the screener and obtained verbal consent for their participation. Fieldworkers were directed to interview the person working at the counter, who interacts with customers. In some cases, that person was the owner or manager, but in others it was somebody else, in which case the interviewers obtained two separate informed consents - one from the owner/manager and one from the participant. Prior to the screening component, fieldworkers were given the list of drug stores from the mapping component, but they were also instructed to document and conduct interviews in any other drug store they saw even if it was not on the list (these were stores that may have been inadvertently missed at the time of the mapping exercise). Seventy-two additional drug sellers were identified by the fieldwork teams, and included in the drug seller screening interviews. In total, 968 drug sellers were screened (Appendix A, Figure 1). Drug sellers received a token of 2,000 Naira (~USD $6) for participating in the screening interview.

The mapping and screening exercises resulted in a list of all drug sellers in the study LGAs that either reported selling misoprostol-containing drugs or did not. Initially, out of 968 drug stores in the universe, 324 drug sellers reported selling misoprostol in the screener, and 644 did not. An additional 16 drug sellers agreed to recruit women into the study, after initially refusing - one that had refused to participate in the screener interview, 13 that had denied selling misoprostol initially in the screener, and two that were approached directly to recruit by the PPMV chairmen in their LGA (Ikorodo). Therefore, the final sample of drug sellers that agreed to recruit women into the study, and whom can be presumed to sell misoprostol, was 340.

Appendix A, Figure 1. Sample of drug sellers, recruitment of women, and retention throughout the study



*16 additional drug sellers who initially denied selling misoprostol or refused to participate in the screener later agreed to recruit women.

3. Recruitment of women by drug sellers

All drug sellers that reported selling misoprostol in the screener were invited to participate in recruiting women into the study. Out of 340 drug sellers that reported selling misoprostol or opted into the study, 227 (67%) agreed to participate in recruiting women, and 148 successfully recruited at least one woman (Appendix A, Figure 1). Before women's recruitment began, drug sellers who had signed up to recruit participated in a one-day training led by the study team, which covered additional background information on the study and training in ethics, maintaining confidentiality, and sensitive recruitment of clients. Drug sellers were trained on logistics for inviting any person (woman or husband/partner/proxy) purchasing misoprostol-containing drugs for any indication, to participate in the study.

Attempts to recruit women into the study were made after the drug seller had provided the drug and any routine counselling to avoid the possibility or perception that their services were contingent upon a woman's participation in the study, and to minimize any influence that study participation would have on the typical drug seller and client interaction. After delivering the normal protocol, the drug seller explained the study using a standard script provided by the study team that included a basic explanation of the study, including incentives for completing the screener interview and two follow up interviews. Anyone interested in participating was asked to verbally agree to be contacted by a member of the study team one to two days after the purchase. Drug sellers provided each woman who agreed to participate with a prepaid phone stocked with 500 Naira (approximately USD $1.50) in airtime and a pamphlet to retain throughout the study. The pamphlet contained a unique participant identification number, but did not include any specific details about the nature of the study. As an additional measure to ensure women's privacy, drug sellers asked each woman to provide a nickname and a password that interviewers could use when calling them, so that they would not have to reveal their real names or personal information to the drug seller during recruitment. The phones were provided to protect women's anonymity and alleviate any potential concerns that their identities would be linked to the study through their own personal, registered, phone numbers (which, in many cases, are linked to women's social media accounts). The idea of giving pre-registered and pre-paid phones to the study participants derived from the experience in the pilot phase of the study, whereby many women did not respond to telephone calls from the interviewers or gave the drug seller the phone number of a husband/partner or friend to contact because of the concern for anonymity.

For cases in which a buyer purchased the drug on behalf of someone else, the drug seller explained the study to the buyer and asked them to contact the potential end-user by calling her mobile phone while the buyer was still at the drug store. During the call, the drug seller briefly explained the study to the end-user and asked if she agreed to be contacted by an interviewer on the research study team, who would later provide her with a more in-depth description of the study and conduct a full informed consent protocol. If the end-user was interested, the drug seller recorded the end-user's responses to the identification questions described above and gave the buyer the study pamphlet and phone to give to the end-user.

Drug sellers were instructed to document the following information in a study log book: the unique ID on the pamphlet given to each woman; the nickname and password that women provided to the drug seller for the purposes of identification to the study team; the phone number of the prepaid phone given to each woman; the purchase data; and permission to be followed up from women who agreed to participate. All potential participants verbally agreed to this information being recorded in the log book and shared with the study team. The nickname and password were used to verify the woman's identity in the event the woman lost the unique identification number. A combination of nickname, password, and the pamphlet unique ID information was required to verify woman's identity at each interview. Drug sellers did not record potential respondents names or any other identifying information, such as individuals' phone numbers, email addressess, or physical addressess.

All drug sellers that volunteered to participate in recruiting women were visited by a member of the study team before recruitment began to verify the availability of a secure storage space for the log books in the facility. Drug sellers were required to store log books in locked and secure cabinets in their stores whenever the log books were not in use. Information on how the log books were stored and retrieved during fielding was also documented by interviewers during weekly site visits to collect physical copies of the log books used for recruitment. The research team initially planned to provide the drug sellers a second logbook to record data on: the total number of clients who came into the drug store requesting help terminating a pregnancy or specifically requesting misoprostol over the data collection

period; clients who purchased an MA drug but did not agree to participate; clients who purchased an MA drug but were not informed about the study; whether the purchaser was the end user or not. This logbook was intended to provide the study team with some additional context and help to understand the extent to which clients were missed by the study. However, after piloting the recruitment process resulted in incomplete and inconsistent data on the number of clients seeking MA or assistance in terminating a pregnancy, and considering the additional burden this logbook would impose on drug sellers during the recruitment period, the effort was dropped. Removal of this additional logbook from the drug seller's recruitment of women prohibited the research team from calculating participation in the study from the total population of clients approached during the fieldwork period.

Each participating drug seller received a prepaid phone and 500 Naira airtime (approximately USD $1.50) at the beginning of the recruitment period and an additional 1,500 Naira (approximately USD $4.50) after the recruitment period was completed. This amount was approved by the IRB as sufficient to reimburse them for the time they spent maintaining records on the study's behalf but not high enough to coerce drug sellers into participating.

Each interviewer for the women's component was assigned between eight and ten drug sellers. During the recruitment period, interviewers contacted each of the assigned drug sellers daily to confirm if the drug seller had recruited any women that day to input the logbook information into SurveyCTO and assess when drug sellers needed additional study materials for recruitment. At the end of the recruitment and follow-up period, interviewers for the women's component retrieved all log books from the drug seller stores and sent them in locked and secured boxes to the in-country study team's offices, to be destroyed at the completion of the study.

4. Prospective cohort study of women

The prospective study of women included three rounds of surveys, using structured questionnaires with each woman, conducted over telephone by members of the study team over the course of one month. At the beginning of each call, interviewers followed a script to confirm the unique participant identification number, nickname, and security password on file to ensure the study team was speaking with the correct person. Once this was established, interviewers obtained verbal consent to participate in each interview. Interviewers did not provide any information about the study to anyone except the respondent, including husbands/partners or individuals who helped purchase the medicine for women.

The initial study design called for interviewers to make three attempts to contact each woman for an interview. Due to difficulties contacting respondents during early data collection, mainly non-response to phone calls from the field team, interviewers continued to call the prepaid phones for a four-week period. According to participants whom fieldworkers were later able to reach, the non-response was due to women not switching on the prepaid phones immediately after purchasing the medicine or not checking and charging the phone's battery regularly. Women working outside the home also reported leaving the study phones at home when they left the house. In total, about three percent of the women recruited into the study by drug sellers (15 women) were never successfully contacted by the study team.

For women who did participate, the average duration of the prospective study from recruitment to completion of the second follow-up interview was 37 days. Approximately 30% of women were reached on the interviewer's first attempted call across the study period; however, more than 20% of participants were called at least five times before interviewers successfully reached them for the screener and the first and second follow-up interviews with up to 16 attempted contacts required to successfully contact some respondents for interviews. While interviewers continued to call when women did not answer the phone, on average, interviewers reached women for the screener and both follow-up interviews on the second or third attempt.

Interviewers were trained to not give advice about any potential complications or directly answer health-related questions at any point in the women's interviews. During the screener or first follow-up interview, women who asked for medical advice or who described symptoms that could indicate a serious problem were provided with the numbers for the Marie Stopes Nigeria hotline and the accident and emergency unit of the Lagos State University Teaching Hospital. All women in the study were given this contact information after completion of the second follow-up interview, in case they had additional medical questions. Women given hotline information in the screener or first follow-up interview were asked if they had contacted the hotlines, during the first and second follow-up

interviews, respectively, to account for any bias this potentially gained information may have introduced into the results. Twelve women requested further information that prompted interviewers to provide the hotline number - two at the time of the screener interview and eleven during the first follow up interview (one woman requested more information during both interviews). However, none of the study participants successfully utilized the hotline.

4.1. Screener Interview

The screener interview was intended to be conducted one to two days after women (or someone else on their behalf) purchased the medicine. However, due to difficulties reaching women, screeners were completed seven days after the purchase on average. The screener interview took approximately five to ten minutes and collected information on age, reason for planned use of medicines purchased, and a measure of literacy. The interviewer only proceeded with enrolling women into the full prospective study if the respondents could be confirmed as the same women who were recruited by the drug seller, through their unique IDs, nicknames, and passwords, and met the eligibility requirements: 18 to 49 years old at the time of the interview and intended to use the medicines purchased to end a pregnancy. Under these criteria, 446 women were eligible for inclusion (Appendix A, Figure 1). Most ineligible women were outside of the age range or planned to use the medicine for another reason (e.g., for gastric ulcers or during childbirth for postpartum haemorrhage). A few of the ineligible respondents were nurses who ran private care centers in their homes and indicated that they had bought the misoprostol from the drug sellers with the intention of selling it later.

After completion of the screener, interviewers obtained informed consent to contact eligible women for the first follow-up interview five to seven days later. Due to the challenges faced in contacting women, the length of time between the purchase of misoprostol and the screener and subsequent interviews varied for some respondents. In cases where the interviewer could not contact the respondent for the screener until five days or later following the purchase of misoprostol, interviewers conducted the screener and first follow-up interview during the same call.

The prepaid phone and airtime provided by the study team through the drug sellers upon recruitment served as the only incentive for the screener, and women were not provided with another incentive at the completion of the call. There was no significant drop out between recruitment and screening or screening and the first follow-up interview to indicate that the provision of the first incentive up-front might have had a negative impact on study retention.

4.2. First Follow-up Interview

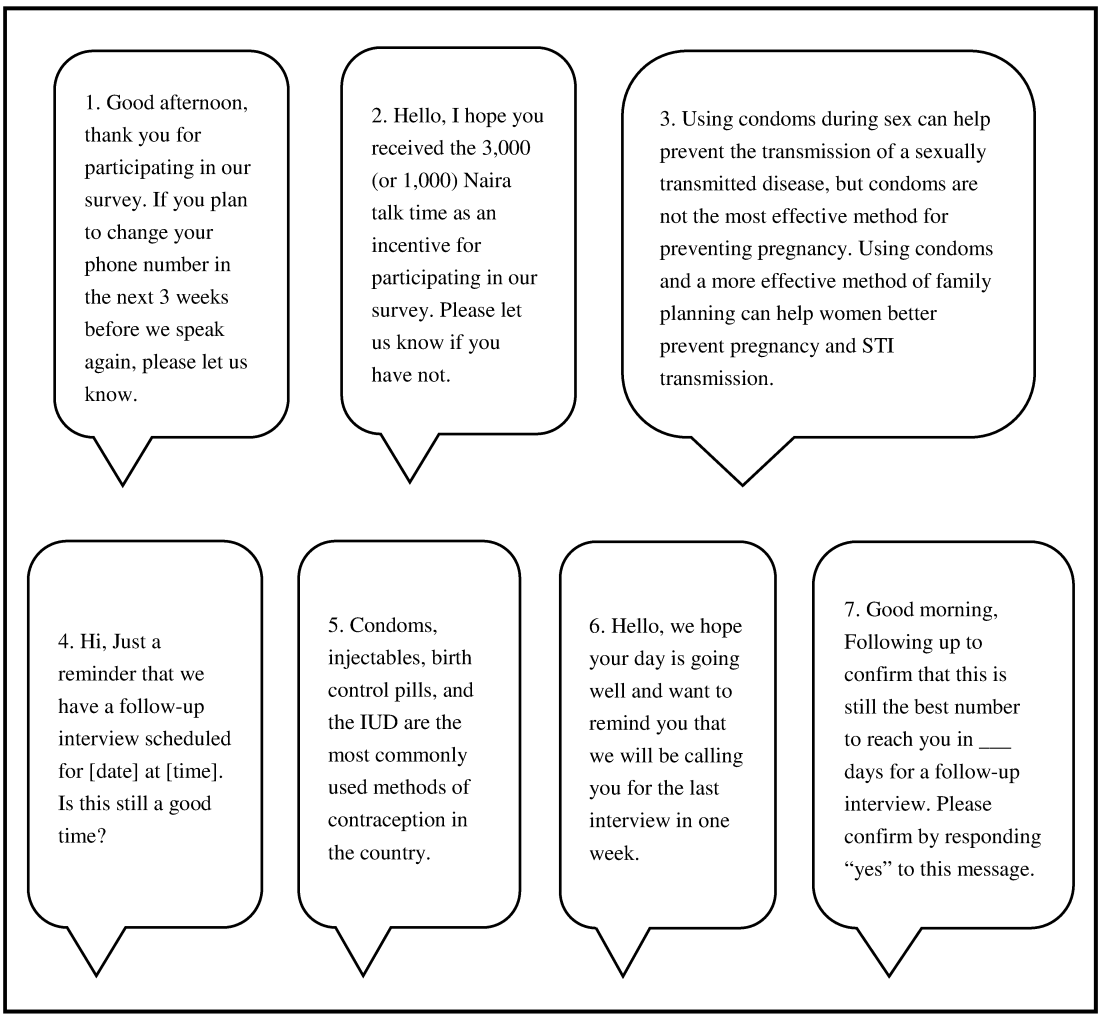
423 women - or 95% of eligible women - agreed to be followed up for another interview about a week after the screener interview (Appendix A, Figure 1). Interviewers followed the same procedure described in point 4 above to confirm women's identities prior to conducting the first follow-up interview. After confirming the person who answered the phone was the correct study participant, the interviewer reiterated the purpose of the study and obtained another verbal informed consent prior to beginning the interview. The purpose of the first follow-up interview was to determine women's decision-making processes around obtaining an abortion from a drug seller; the types of medication each woman purchased (some women purchased other abortifacients, including mifepristone alone and combi-packs of misoprostol and mifepristone); establish if the woman had used the medication; and collect information on her interaction with the drug seller, including the instructions drug sellers had given to each woman on how to take the regimen purchased.

At the end of the first follow-up interview, interviewers obtained informed consent to contact eligible women for the second follow-up interview approximately three weeks later (and approximately one month after the medication was purchased). Women who completed the first follow-up interview in the first three LGAs (Lagos Mainland, Ojo, and Ishodi/Isolo) received a 3,000 Naira (~USD $8) airtime incentive. This amount was originally considered to be enough to encourage women to participate but not so much that it would coerce women into participating. However, the incentive was reduced during the data collection in the second set of three LGAs (Epe, Ibeju-Lekki, and Ikorodu) to 1,000 Naira (~USD $3) in airtime due to budgetary constraints and confirmation by the field team that the new amount proposed then was adequate. The geographical location of the second set of LGAs made the cost of conducting the study in the areas, among others, much higher than those in the first set of LGAs particularly in terms

of transportation cost and accommodation for data collectors. While the incentives for women in the second three LGAs was about a one-third of those offered to women in the first three LGAs, there was no similar difference in the completion rates: 94% of eligible women from the first three LGAs completed the first follow-up interview compared with 97% of eligible women in the second three LGAs.

In the three-week period between the first and second follow-up interviews, interviewers engaged in consistent outreach via SMS message with each participant (Appendix A, Figure 2). These messages allowed interviewers to send reminders about the upcoming second follow-up interview and generally engage with the women. The purpose of the messages was to help retain participants in the study without sending any identifiable information or further details about the purpose of the study.

Appendix A, Figure 2. Text messages sent to respondents between the first and second follow-up interviews



4.3. Second Follow-up Interview

394 - 93% of women who completed the first follow-up interview - consented to be contacted for a second follow-up interview about 21 days later (Appendix A, Figure 1). Interviewers followed the same procedure described in point 4 above to confirm women's identities prior to conducting the second follow-up interview. After confirming they were speaking to the correct study participant, the interviewer reiterated the purpose of the study and obtained verbal informed consent prior to beginning the interview. The primary focus of the second follow-up interview was to understand women's self-reported health outcomes after taking the medication; experiences with side effects and potential complications and whether women sought further healthcare after taking the medication; how women assess the completion of their abortions; the availability of emotional or social support throughout the process; and women's willingness to recommend medication abortion to friends or use it again in the future. Women who completed the second follow-up interview received an additional 3,000 or 1,000 Naira airtime incentive, in the first three or second three LGAs, respectively. Again, this difference in incentives was not reflected in the success rates: 94% of women who completed the first follow-up interview in the first three LGAs compared with 91% of those in the second three LGAs went on to complete the second follow-up interview.

During the programming of the study tools, a question on parity was inadvertently dropped. After exploring preliminary data, the study team agreed that interviewers should incorporate that question into all fieldwork that had not yet concluded. The team also attempted to recontact women who had already completed both follow-up interviews to ask about parity. The team successfully obtained measures of parity from 227 of the 394 respondents that completed the second follow-up interview.

Appendix B. Construction of Key Variables

The study team constructed variables to estimate the appropriateness of the dosage women received, the instructions women received on the route of administration of the pills, the adequacy of the information and instructions women received from drug sellers, and experiences with warning signs that could indicate potential complications. These measures are described below.

1. Dosage
To assess whether women purchased or were instructed to use the medication in the correct (i.e. WHO recommended) dosage, the team first determined what types of medication women were sold. This determination was based either on what was written on the manufacturer's package (if it was sold in a package and the package was still available at the time of the second interview), women's self-report of what the drug seller had told them, or their descriptions of the type of packaging and the number, color, or shape of the tablets they purchased. After determining that the medicine purchased was misoprostol, the dosage based on the number of pills purchased (assuming each misoprostol pill contains 200 mcg) was calculated. Dosages for misoprostol were categorized as less than 800 mcg (< four tablets), 800 mcgs (four tablets), 1000-1400 mcgs (five to seven tablets), and 1600-2400 mcgs (eight to 12 tablets). Nobody in the sample was given more than 12 tablets. To help in this process, the team compiled a list of misoprostol-containing drugs, including those that were registered with the government, brand names that were unregistered but found in the participating drug stores, and those that were identified by medical doctors and pharmacists on the research team. For the few women who received a combination pack of mifespristone and misoprostol, the recommended dose was defined as 200 mg mifepristone and 800mcg misoprostol, per standard packaging dosages.

2. Route of administration
According to clinical guidelines, mifepristone should be swallowed orally, and the optimal administration routes for misoprostol are vaginal, buccal (letting the pills dissolve in the cheek), or sublingual (letting the pills dissolve under the tongue). In assessing the appropriateness of the instructions given to women on how to administer the medication, any instructions that mentioned the option to ingest the misoprostol orally were considered suboptimal. The route of administration was categorized as optimal if women were told to take the misoprostol alone buccally, sublingually, or vaginally. For women who received mifepristone and misoprostol, the team categorized administration routes that included taking one mifepristone orally and misoprostol buccally, sublingually, or vaginally as optimal.

3. Core information score
Given that the safety and effectiveness of self-managed medication abortion depends, in part, on users' access to accurate information, the research team was interested in assessing the accuracy of information women received from drug sellers in the study. A score was constructedbased on the medical literature, consisting of nine items considered to be reasonably necessary, for women to successfully self-manage their abortions and assess the appropriateness of the information women received from drug sellers. Each item in the score was assigned one point, as no particular item warranted more weight than the others.

Items included:

1. Woman was asked about timing of last menstrual period
2. Woman was asked if she had taken a pregnancy test
3. Woman was told that bleeding is a side effect of the medication
4. Woman was told that cramping is a side effect of the medication
5. Woman was told that severe or prolonged bleeding could indicate a complication for which she might need to seek medical care
6. Woman was told that severe or prolonged pain could indicate a complication for which she might need to seek medical care
7. Woman was told that she could or should use pain medication
8. Woman was told anything about how to recognize a potential allergic reaction
9. Woman was told anything about potential contraindicated drugs

The data collected through this series of nine questions are limited and insufficient to provide a true measure of accuracy. For example, women may have reported that the drug seller informed them of potential drug contraindications, but this measure does not include information about what specific contraindications were mentioned, and therefore, cannot precisely assess the accuracy of the information given. Nevertheless, the data generated could inform whether the types of information provided were within the bounds of what would be appropriate to cover and could reasonably be expected as the minimum amount of information women should receive.

4. Women's experience with potentially problematic effects of the medication

This study attempted to assess the proportion of women who experienced postabortion complications using their self-reported symptoms after using the medications purchased from the drug seller. To construct measures for estimating potentially problematic clinical effects that could indicate complications, the team created algorithms to assess excessive or greater than anticipated bleeding and signs of an infection.

Bleeding that could be symptomatic of a potential complication:

- Bleeding that soaks through more than two regular sized pads in two hours, lasting consistently for 12 hours after taking the medication.

Pain that could be symptomatic of a potential complication:

- Abdominal pain self-reported as greater than five on a one to 10 pain scale that lasted more than 24 hours after taking the medication and was not alleviated by taking pain medication, or
- Abdominal pain self-reported as greater than five on a one to 10 pain scale that occurs with nausea and (vomiting or diarrhea) that lasted more than 24 hours after taking the medication, or
- Abdominal pain at the time of the last interview (~ one month after taking the medication), that was rated qualitatively by women as being "moderate" or "severe" or greater than five on the one to 10 pain scale and that had either lasted more than six days, or had not improved over time.

Fever or chills that could be symptomatic of a potential complication:

- Fever or chills that lasted more than 24 hours after taking the medication, or
- Any fever or chills still experienced at the time of the last interview.

Foul-smelling or discolored discharge that could be symptomatic of a potential complication:

- Foul smelling or discolored (not clear or white) discharge after taking the medication, or
- Foul smelling or discolored discharge at the time of the last interview that had either lasted for more than six days or had not improved over time.

Anyone who had a potential pain-, fever/chills-, or discharge-related complication was considered to have potentially experienced an infection complication after taking the medication. These measures likely overestimate potential complications in the sample as any self-report of a potential symptom qualifies respondents for inclusion in these estimates.

Appendix C: Supplementary Tables

Appendix C, Table 1. Women's experiences with previous attempts to end current pregnancy prior to recruitment

	Among women who completed both follow-up interviews (n=394)	
	%	No.
Women who made another attempt to end the pregnancy prior to being recruited	5.3	21
Among women who had made a prior attempt (N=21):		
Number of previous attempts to end the pregnancy		
1	81.0	17
2	14.3	3
>2	4.8	1
Women who went to each place in their last attempt		
Another pharmacy/drugstore	23.8	5
The same pharmacy/drugstore	14.3	3
Traditional practitioner	23.8	5
A friend	19.0	4
Did something at home	19.0	4
Women who used each method in their attempt(s)*		
Took some pills	57.1	12
Drank agbo/herbal preparation	47.6	10
Other	10.0	2
Pills women had taken in previous attempts (N=12)		
Misoprostol	16.7	2
Postinor (emergency contraception)	33.3	4
Don't know	50.0	6
Outcome of attempt(s)		
Nothing/light spotting	100.0	21

* Multiple responses were allowed

Appendix C, Table 2. Women's reports of information received from the drug seller, clinical symptoms experienced after taking the medication, and dosages given, according to whether or not we verified that they had received misoprostol

	Women who we verified received misoprostol (n=323)		Women who we could not verify received misoprostol (n=71)		All women who completed both follow-up interviews (n=394)		P-value
	%	No.	%	No.	%	No.	
Proportion who were told about clinical effects to expect*							
Bleeding	65.3	211	71.8	51	66.5	262	0.293
Cramping/Abdominal Pain	34.7	112	38.0	27	35.3	139	0.592
Headaches	9.0	29	2.8	2	7.9	31	0.081
Vomiting	4.6	15	4.2	3	4.6	18	0.878
Nausea	1.5	5	--	--	1.3	5	0.291
Diarrhea	2.2	7	1.4	1	2.0	8	0.681
Fever/chills	3.7	12	5.6	4	4.1	16	0.458
General feeling of weakness	14.9	48	16.9	12	15.2	60	0.665
Dizziness	0.9	3	--	--	0.8	3	0.415
Proportion who reported experiencing clinical effects after taking the medication*							
Bleeding	83.3	269	90.1	64	84.5	333	0.148
Cramping/Abdominal Pain	69.7	225	74.6	53	70.6	278	0.404
Headaches	8.7	28	7.0	5	8.4	33	0.654
Vomiting	5.6	18	4.2	3	5.3	21	0.647
Nausea	3.1	10	2.8	2	3.0	12	0.901
Diarrhea	5.6	18	2.8	2	5.1	20	0.338
Fever/chills	8.7	28	7.0	5	8.4	33	0.654
Foul smelling or colored vaginal discharge	0.6	2	--	--	0.5	2	0.506
General feeling of weakness	22.3	72	11.3	8	20.3	80	0.037
Dizziness	2.5	8	1.4	1	2.3	9	0.585
Amongst women that were told about bleeding:							
Women reported bleeding	87.2	184	98.0	50	89.3	234	0.025
Amongst women that were told about cramping:							
Women reported cramping	75.0	84	70.4	19	74.1	103	0.622
Women reporting a complete abortion without surgical intervention	94.4	305	90.1	64	93.7	369	0.180
Miso dose	**n=249**		**n=0**		**n=249**		NA
<800mcg misoprostol	69.1	172	NA	NA	69.1	172	
800mcg misoprostol	26.9	67	NA	NA	26.9	67	
1000-1400mcg misoprostol	2.0	5	NA	NA	2.0	5	
1600mcg-2400mcg misoprostol	0.8	2	NA	NA	0.8	2	
200mg mifepristone & 800mcg misprostol	1.2	3	NA	NA	1.2	3	

* Multiple responses were allowed.

Appendix C, Table 3. Proportion of women reporting complete abortions without surgical intervention ~one month after taking the medication, according to the dosages received

	Number of women that received each dosage (n=249)	Completed abortions among women who you received each dosage of medication	
		%	No.
Misoprostol dosage			
<800mcg misoprostol	172	93.0	160
800mcg misoprostol	67	97.0	65
1000-1400mcg misoprostol	5	80.0	4
1600mcg-2400mcg misoprostol	2	100.0	2
200mg mifepristone & 800mcg misprostol	3	100.0	3

Appendix C, Table 4. Estimated proportion of all women with completed abortions using different assumptions for women lost to follow up

	Completed abortions among all women who confirmed taking the pills (n=423)	
	%	No.
Assumptions about women lost to follow up		
All women had incomplete abortions	87.2	369
25% of women had complete abortions	88.9	376
50% of women had complete abortions	90.7	384
75% of women had complete abortions	92.4	391
All women had complete abortions	94.1	398

Appendix C, Table 5. Drug store and drug seller characteristics among drug sellers that did and did not agree to recruit women

	Drug sellers who agreed to recruit women (n=224*)		Drug sellers who did not agree to recruit women (n=113)		P-value
	%	No.	%	No.	
Drug Store Characteristics					
Drug store area					0.023
Urban	96.9	217	91.2	103	
Peri-urban	3.1	7	8.8	10	
Drug store LGA					0.000
Lagos Mainland	19.6	44	14.2	16	
Ojo	18.3	41	10.6	12	
Oshido/Isolo	33.0	74	11.5	13	
Epe	4.0	9	4.4	5	
Ikorodu	17.0	38	44.2	50	
Ibeju-Lekki	8.0	18	15.0	17	
Type of drug store					0.011
Pharmacy	68.3	153	81.4	92	
Proprietary Patent Medicine Vendor (PPMV)	31.7	71	18.6	21	
Does store sell family planning products					0.758
No	1.3	3	1.8	2	
Yes	98.7	221	98.2	111	
Drug Seller Characteristics					
Drug seller Position					0.686
Owner/Senior manager	43.8	98	43.4	49	
Front counter staff - pharmacist	33.5	75	32.7	37	
Front counter staff - non-pharmacist	20.1	45	23.0	26	
Other	2.7	6	0.9	1	
Drug seller Sex					0.050
Male	61.6	138	50.4	57	
Female	38.4	86	49.6	56	
Drug seller Age					
Median (IQR)	32	(27-39)	34	(28-42)	

* Three drug sellers that recruited women did not complete the drug seller screener and are not included in this table.